

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

FILED
U.S. DISTRICT COURT
DISTRICT OF NEBRASKA

2005 AUG -5 PM 2: 50

OFFICE OF THE CLERK

UNITED STATES OF AMERICA,

Plaintiff,

v.

THOMAS P. MCGINN,

Defendant.

4:99CR3074

ORDER OF SELF SURRENDER

On Friday, August 5, 2005, the court received medical information from the defendant's counsel in accordance with my order of August 3, 2005, which information shall be filed as a part of the court file. It recites a diagnosis of a left inguinal hernia, for which the defendant's surgery was scheduled for August 26, 2005, followed by a requirement of no days in the hospital post-surgery but an additional 7 to 21 days at home to recuperate including "activity as tolerated from now through the next 9 weeks." A post-op appointment was scheduled for September 9, 2005.

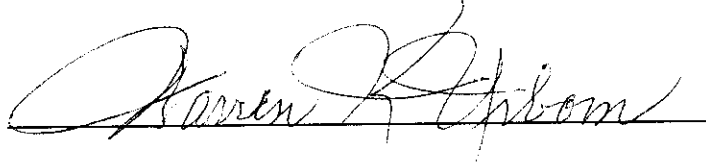
In view of the magistrate judge's recent finding of the need for execution of an appearance and compliance bond and a subsequent finding of need for detention, as well as the defendant's admission to me on August 3, 2005, of failure to comply with a condition of his supervised release, I find that there is no special circumstance which justifies a lack of detention of the three weeks that would be involved in performance of the called-for surgery of August 26, 2005. He should, therefore, begin his sentence of imprisonment without delay.

IT IS ORDERED that (1) the medical information mentioned above and marked defendant's Exhibit A shall be filed; (2) the defendant shall self surrender to the United States Marshal or his deputy at the United States Courthouse in Lincoln, Nebraska, no later than 2:00 p.m. on Monday, August 8, 2005, for the commencement of his sentence of August 3, 2005; and (3) the defendant's medical records filed with this order shall be transmitted promptly for use by

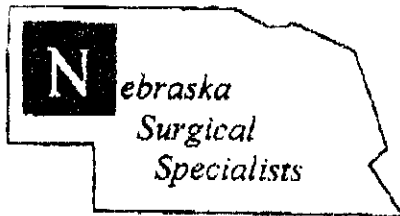
the Bureau of Prisons to determine what and when appropriate surgery or other medical treatment should be furnished to the defendant.

Dated August 5, 2005.

BY THE COURT

A handwritten signature in black ink, appearing to read "Warren K. Urbom", written over a horizontal line.

Warren K. Urbom
United States Senior District Judge



2222 South 16th Street
Suite 200
Lincoln, Nebraska 68502
Telephone 402-475-9090
FAX 402-475-9092
www.nebsurg.com

COPY

Miles C. Tommeraaen, M.D.

Carolyn S. Cody, M.D.

John F. Cordova, M.D.


August 5, 2005

To the United States District Court
For the District of Nebraska

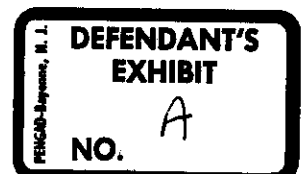
RE: Thomas McGinn

This confirms I saw Thomas McGinn in my office on Friday, August 5, 2005 for a surgical consult. His diagnosis is Left inguinal Hernia. His surgery is scheduled for August 26, 2005. He will require 0 days in the hospital post-surgery and an additional 7-21 days at home to recuperate. His restrictions include Activity as Tolerated from now through the next 9 weeks. There is a post-op appointment scheduled for 9/9/05 - LH.

If you require additional information, please contact my office at phone number 402-475-9090


Dr. Miles C. Tommeraaen
2222 S. 16th Street, Suite 200
Lincoln, NE 68502

Board Certified Surgeons
General surgery... Laparoscopic surgery... Breast surgery... Weight reduction surgery
Hernia repair... Surgery of the digestive tract... Trauma surgery



BryanLGH Medical Center-East - Lincoln , NE 68506-1299**Patient:** MCGINN, THOMAS P**DOB:** 12/25/1964**Age/Gender:** 40 M

7/25/2005 08:06 Groin pain

MR#: 000925810**Acct#:** 800475316**Private Phys:** Timothy H. Fischer MD**ED Phys:** Brent C. Bunz, MD**CHIEF COMPLAINT:**

Enc. Type: Initial**ACUITY:** 3- Urgent

Groin pain

Physicians caring for patient:

Brent C. Bunz, MD

VITAL SIGNS

Initials/Date/Time	Temp(F)	Rt.	Pulse	Resp	Syst	Diast	Pos.	O2 Sat	Rhythm	Amt O2
HJT 7/25/2005 08:13	97.2	T	<u>112</u>	<u>24</u>	<u>141</u>	86	S	99		
KLW 7/25/2005 12:04			87	16	124	73	S			

TRIAGE**Yes, I am having pain related to today's visit.**<HJT 07/25/05 08:10>

Arrival: Patient arrived ambulatory via private auto from home. Accompanied by: self. The patient entered the ED through the main entrance.<HJT 07/25/05 08:08>

Chief complaint quote/note: Pt. states he was lifting a jet ski one week ago and "pulled something" in his left groin area. He states he now has swelling and increased pain.<HJT 07/25/05 08:09>Date and/or time symptoms started: Monday, July 18, 2005 <HJT 07/25/05 08:09>
<HJT 07/25/05 08:09>**PCP:** Timothy H. Fischer, MD<HJT 07/25/05 08:10>**FLWSHEETS****Input**

Initials	Time	IV	Blood	PO	Total
KLW	7/25/2005 11:17			1000 ml	1000 ml

MEDICATION ADMINISTRATION

Saline flush Normal Saline 0.9% 10 ml; Route: IV flush (3 times in MAR) <Brent C. Bunz, MD 7/25/2005 08:48>

Given , per IV Push 10 ml. IV site # 1
KLW 7/25/2005 09:15Given , per IV Push 10 ml
KLW 7/25/2005 09:35Given , per IV Push 10 ml. IV site # 1
KLW 7/25/2005 10:02

Morphine 2-5 mg; Route: IV x1 PRN pain; Maximum dose =20 mg (3 times in MAR) <Brent C. Bunz, MD 7/25/2005 08:49>

BryanLGH Medical Center-East - Lincoln , NE 68506-1299

Patient: MCGINN, THOMAS P

DOB: 12/25/1964

Age/Gender: 40 M

7/25/2005 08:06 Groin pain

MR#: 000925810

Acct#: 800475316

Private Phys: Timothy H. Fischer MD

ED Phys: Brent C. Bunz, MD

Given , per IV Push 2 mg. IV site # 1

KLW 7/25/2005 09:12

Notes:

<KLW 07-25-2005 11:16>1104 - 6 mg Morphine given IV per site #1 followed by 10mg on Normal Saline IV site #1..

Given , per IV Push 2 mg. IV site # 1

KLW 7/25/2005 09:14

Response unchanged. anxiety

KLW 7/25/2005 09:30

Given , per IV Push 10 mg. IV site # 1

KLW 7/25/2005 09:31

Response Moderate pain relief 5/10 anxiety

KLW 7/25/2005 10:00

Toradol 30 mg; Route: IV <Brent C. Bunz, MD 7/25/2005 09:59>

Given , per IV Push 30 mg. IV site # 1

KLW 7/25/2005 10:01

Response unchanged. 6/10

KLW 7/25/2005 10:30

BryanLGH Medical Center-East - Lincoln , NE 68506-1299

Patient: MCGINN, THOMAS P

DOB: 12/25/1964

Age/Gender: 40 M

7/25/2005 08:06 Groin pain

MR#: 000925810

Acct#: 800475316

Private Phys: Timothy H. Fischer MD

ED Phys: Brent C. Bunz, MD

NURSING

Pain Index - no goal

Initials	Time	Words to describe	Injury/position	Location	Pain index	Behaviors/Clinical signs	Edit Info
KLW	7/25/2005 11:43		right	groin	6/10	Resting quietly	

Pain Index (Adult)

Initials	Time	Words to describe	Injury/position	Location	Pain index	Behaviors/Clinical signs	Aggravating factors	Alleviating factors	Goal for pain relief	Edit Info
HJT	7/25/2005 08:10	burning	left	groin	6/10					
KLW	7/25/2005 12:04	burning	left	groin	6/10	moaning				

BryanLGH Medical Center-East - Lincoln , NE 68506-1299

Patient: MCGINN, THOMAS P

DOB: 12/25/1964

Age/Gender: 40 M

7/25/2005 08:06 Groin pain

MR#: 000925810

Acct#: 800475316

Private Phys: Timothy H. Fischer MD

ED Phys: Brent C. Bunz, MD

HISTORY OF PRESENT ILLNESS

NOTE

Gender and Age: Patient is a 40 year(s) old male <BCB 07/25/05 08:57>

History of present illness obtained from the patient <BCB 07/25/05 08:57>

Medical and surgical history obtained. <BCB 07/25/05 08:58>

Social history obtained. <BCB 07/25/05 08:58>

HPI note documented by dictation. <BCB 07/25/05 08:57>

Notes:

<Y 07/27/05 09:54:58>

DICTATED HISTORY OF PRESENT ILLNESS:

This 40-year-old male presents with complaints of abdominal pain and a possible hernia. He states that this past Monday, July 18, he and two other individuals were lifting a jet ski onto a trailer. As he was bending forward to lift this jet ski, he had the abrupt onset of pain in the left groin. He has had it intermittently ever since July 18. The pain now is much worse since 4 AM, and he thus presents now to have it evaluated. He states over the past few days, the pain is almost nonexistent when he awakes in the morning. He states as the day progresses, he has increased pain in his left groin and he notices a lump the size of a golf ball. He states when he goes to bed, all these symptoms would usually subside and the cycle would repeat itself the following day. He states though last night he was more uncomfortable through the night sleeping. He awoke around 4 AM with increased pain and has not been able to tolerate it ever since. It is a burning, 6/10 pain in his left groin only. He has not noted the lump this morning, but states that comes and goes. He has no dysuria or frequency. He has no diarrhea or constipation, and no associated nausea, vomiting, or other complaints of abdominal pain. He has never had discomfort like this before. Treatment has included nothing. He further denies any pain in his testicle or penis.

BB/das #000613475 D 07/25/2005 T 07/27/2005

PAST HISTORY

PAST MEDICAL/SURGICAL HISTORY

No significant surgical history. <BCB 07/25/05 08:58>

The patient's pertinent past medical history is as follows: Depression <BCB 07/25/05 08:58>

PAST SOCIAL HISTORY

Patient does not use tobacco. <BCB 07/25/05 08:58>

Patient does not use alcohol. <BCB 07/25/05 08:58>

Patient does not use drugs. <BCB 07/25/05 08:58>

Living arrangement: . Patient lives locally. <BCB 07/25/05 08:58>

REVIEW OF SYSTEMS

ALL OTHER SYSTEMS NEGATIVE

BryanLGH Medical Center-East - Lincoln , NE 68506-1299

Patient: MCGINN, THOMAS P

DOB: 12/25/1964

Age/Gender: 40 M

7/25/2005 08:06 Groin pain

MR#: 000925810

Acct#: 800475316

Private Phys: Timothy H. Fischer MD

ED Phys: Brent C. Bunz, MD

As documented in HPI, all other systems are negative for acute conditions.<BCB 07/25/05 08:57>

EXAM

GENITOURINARY

CONSTITUTIONAL: Well-appearing; well-nourished; in no apparent distress

HEAD: Normocephalic; atraumatic

EYES: PERRL; EOM intact

ENT: TM's normal; normal nose; no rhinorrhea; normal pharynx with no tonsillar hypertrophy

NECK: Supple; non-tender; no cervical lymphadenopathy

CARD: Normal S1, S2; no murmurs, rubs, or gallops

RESP: Normal chest excursion with respiration; breath sounds clear and equal bilaterally; no wheezes, rhonchi, or rales

ABD: Normal bowel sounds; non-distended; Left inguinal region is tender on palpation; no palpable organomegaly. The remaining abdomen is not tender.

EXT: Normal ROM in all four extremities; non-tender to palpation; distal pulses are normal

SKIN: Normal for age; warm; dry; good turgor; no apparent lesions <BCB 07/25/05 08:59>

No flank pain or CVA tenderness with palpation.<BCB 07/25/05 08:59>

Penis: normal in appearance.<BCB 07/25/05 08:59>

Scrotum: no lesions or discoloration noted.<BCB 07/25/05 08:59>

Testes/epididymis: bilaterally descended and non-tender.<BCB 07/25/05 08:59>

ORDERS

MEDICINE

Saline flush Normal Saline 0.9% 10 ml; Route: IV flush (3 times in MAR) Brent C. Bunz, MD 7/25/2005 08:48

Morphine 2-5 mg; Route: IV x1 PRN pain; Maximum dose =20 mg (3 times in MAR) Brent C. Bunz, MD 7/25/2005 08:49

Toradol 30 mg; Route: IV Brent C. Bunz, MD 7/25/2005 09:59

LAB

; Category: Frequent Orders; Test: CBC (Complete Blood Count) [Reference: 800475316-00001]< Brent C. Bunz, MD 7/25/2005 08:47 >

; Category: Chemistry; Test: LACTIC ACID (L-LACTATE) [Reference: 800475316-00002]< Brent C. Bunz, MD 7/25/2005 08:47 >

; Category: Urine; Test: Clean Catch UA [Reference: 800475316-00003]< Brent C. Bunz, MD 7/25/2005 08:47 >

RADIOLOGY

Category: ; Exam: CT ABD/PELV W CONT; Reason for order: Abdominal tenderness; Transportation mode: Cart [Reference: 800475316-00004]< Brent C. Bunz, MD 7/25/2005 08:55 >

Special Instructions

Hernia evaluation.

TREATMENT

General orders; Orders catgy: Insert Saline lock < Brent C. Bunz, MD 7/25/2005 08:48>

CONSULTATION

Consult order for specialty: General Surgery; Physician Carolyn S. Cody, MD < Brent C. Bunz, MD 7/25/2005 11:48>

BryanLGH Medical Center-East - Lincoln , NE 68506-1299

Patient: MCGINN, THOMAS P

DOB: 12/25/1964

Age/Gender: 40 M

7/25/2005 08:06 Groin pain

MR#: 000925810

Acct#: 800475316

Private Phys: Timothy H. Fischer MD

ED Phys: Brent C. Bunz, MD

Procedure: E-CT ABD/PELV W CONT
DOS: 07/25/2005 11:23
Admitting Dx: ABD PAIN
Indications: ABDOMINAL TENDERNESS
CPT Code(s): 74160 72193

CLINICAL HISTORY: Abdominal tenderness.

FINDINGS:

7.5 mm thick sections were obtained through the abdomen and pelvis after oral and 150 cc intravenous Omnipaque 350 contrast administration. Subsequent 3.8 mm images were reconstructed through the pelvis. Limited images of the lung bases show mild emphysematous changes in the anterior left lung base. Images were obtained while the patient performed the Valsalva maneuver.

The solid organs are unremarkable in appearance. Mild vascular calcifications are seen within the aorta and branch vessels.

Within the pelvis, very small left inguinal hernia is noted with minimal herniation of the colon at the junction of the descending and sigmoid colon. There is no evidence of bowel wall thickening, pneumatosis or free fluid. No additional significant abnormalities are noted.

IMPRESSION:

1) Small left inguinal hernia containing very small portion of colon with no evidence of obstruction or wall thickening.

2) Mild chronic findings including emphysematous changes in the left lung base and vascular calcifications.

Reading Physician: Kim L Coleman, M.D. Radiologist

Result 2 <User N. Interface 7/25/2005 14:11>

Category: ; **Exam:** CT ABD/PELV W CONT; **Reason for order:** Abdominal tenderness; **Transportation mode:** Cart

Procedure: E-CT ABD/PELV W CONT
DOS: 07/25/2005 11:23
Admitting Dx: ABD PAIN
Indications: ABDOMINAL TENDERNESS
CPT Code(s): 74160 72193

CLINICAL HISTORY: Abdominal tenderness.

FINDINGS:

7.5 mm thick sections were obtained through the abdomen and pelvis after oral and 150 cc intravenous Omnipaque 350 contrast administration.

BryanLGH Medical Center-East - Lincoln , NE 68506-1299

Patient: MCGINN, THOMAS P

DOB: 12/25/1964

Age/Gender: 40 M

7/25/2005 08:06 Groin pain

MR#: 000925810

Acct#: 800475316

Private Phys: Timothy H. Fischer MD

ED Phys: Brent C. Bunz, MD

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IMPRESSION:

- 1) Small left inguinal hernia containing very small portion of colon with no evidence of obstruction or wall thickening.
- 2) Mild chronic findings including emphysematous changes in the left lung base and vascular calcifications.

Reading Physician: Kim L Coleman, M.D. Radiologist

PROGRESS NOTES

Notes:

<Y 07/27/05 11:00:28>

Dictated Medical Decision Making:

This 40-year-old male was evaluated for complaints of abdominal and groin pain. On examination I did not see an obvious hernia through standing, supine examination, with and without Valsalva maneuvers. He did though have quite a bit of pain in his left inguinal region and gives a fairly consistent history with a hernia. Again, he was experiencing quite a bit of pain; thus, a CT was performed to make sure there was no evidence of incarceration present. Dr. Coleman our radiologist does see a hernia at the junction of the descending and sigmoid colons. It involves only the lateral wall and she does not see any signs of inflammation or wall thickening. I did perform a CBC and a lactic acid level, which are both normal. The patient did not have a surgical request and he did not want me to call his regular doctor for a referral. I thus contacted Dr. Cody's office as she is on-call for general surgery. She was in the operating room, so I did not want to bother her. I did discuss the case with her nurse though and the patient was given Dr. Cody's name for follow-up if he desires. I emphasized that this would be something that would likely need to be surgically repaired as it is bothering him quite a bit. I wrote him for some pain tablets as needed. He was discharged in stable condition with hernia instructions.

BB/jkb #000613750 D 07/25/2005 T 07/27/2005

BryanLGH Medical Center-East - Lincoln , NE 68506-1299**Patient:** MCGINN, THOMAS P**DOB:** 12/25/1964**Age/Gender:** 40 M

7/25/2005 08:06 Groin pain

MR#: 000925810**Acct#:** 800475316**Private Phys:** Timothy H. Fischer MD**ED Phys:** Brent C. Bunz, MD**DIAGNOSIS**

Hernia - inguinal, left

<BCB:Brent C. Bunz, MD 07/25/05 08:59>

PRESCRIPTIONS

Hydrocodone/APAP 5/500 - Twenty (# 20); Take one to two tablets by mouth every four to six hours as needed for pain - Refills: None Brent C. Bunz, MD 7/25/2005 11:55

AFTERCARE INSTRUCTIONS

General Discharge Instructions - English<BCB 07/25/05 11:55>

Hernia (inguinal - Ventral - Umbil) - English<BCB 07/25/05 11:55>

NURSING NOTES

07/25/05 08:10 Pain index (Adult)

Words to describe: burning**Aggravating factors:****Injury/position:** left**Alleviating factors:****Location:** groin**Goal for pain relief:****Pain index:** 6/10

Entered: <HJT 7/25/2005 08:11>

Behaviors/Clinical signs:

07/25/05 08:13	Temp(F)	Rt.	Pulse	Resp	Syst	Diast	Pos.	O2 Sat	Rhythm	Amt O2
	97.2	T	112	24	141	86	S	99		

Entered: <HJT 7/25/2005 08:14>

07/25/05 08:18 **Allergies:** No known allergies. Entered: <KLW 7/25/2005 08:18>07/25/05 08:19 **Home Medications:** Patient did not bring home medications.**Zoloft PO 30 mg every day** Entered: <KLW 7/25/2005 08:19>

07/25/05 08:19 No, I do not currently use herbals/alternative medicine supplements/dietary supplements. Entered: <KLW 7/25/2005 08:19>

07/25/05 08:19 **Medications were not taken prior to arrival to the ED.** Entered: <KLW 7/25/2005 08:19>07/25/05 08:19 **Immunization status:** Not applicable to chief complaint. Entered: <KLW 7/25/2005 08:19>

07/25/05 08:19 No, I have not had concerns about my appetite/weight in the last 3 months. Entered: <KLW 7/25/2005 08:19>

07/25/05 08:19 No, I do not have spiritual/cultural requests and/or practices. Entered: <KLW 7/25/2005 08:19>

07/25/05 08:19 No, there are not communication barriers. Entered: <KLW 7/25/2005 08:19>

07/25/05 08:19 Patient's fall score is less than or equal to 50. Entered: <KLW 7/25/2005 08:19>

07/25/05 08:19 **Safety:** The patient was brought to room ambulatory by ED staff from triage. Patient was changed into gown without assistance. Bed: placed in low/locked position. Call light is within reach. Plan of care: observe/reassure. Plan of care: warm blanket Entered: <KLW 7/25/2005 08:19>

07/25/05 08:20 General survey Entered: <KLW 7/25/2005 08:20>

07/25/05 08:20 General survey: Mental status: Patient is awake, alert, and cooperative with an affect that is calm and appropriate. The patient is oriented x 3, , and behaving in an age appropriate manner. The patient is speaking coherently. and speaking appropriately for age. Entered: <KLW 7/25/2005 08:20>

07/25/05 08:20 Signs of distress Entered: <KLW 7/25/2005 08:20>

07/25/05 08:20 Signs of distress: Pain: [+] Entered: <KLW 7/25/2005 08:20>

07/25/05 08:20 Inguinal area Entered: <KLW 7/25/2005 08:20>

Note:

<KLW 07-25-2005 08:21>pt. states as the day goes on and that he is on his feet the area will swell

BryanLGH Medical Center-East - Lincoln , NE 68506-1299**Patient:** MCGINN, THOMAS P**DOB:** 12/25/1964**Age/Gender:** 40 M

7/25/2005 08:06 Groin pain

MR#: 000925810**Acct#:** 800475316**Private Phys:** Timothy H. Fischer MD**ED Phys:** Brent C. Bunz, MD

and get hard and increase in pain.

07/25/05 09:00 Urine obtained Entered: <KLW 7/25/2005 09:20>
Note:
 <KLW 07-25-2005 09:20>unable to void at this time.

07/25/05 09:10 IV placement: IV site # 1: a/an 18 Gauge was inserted in the right antecubital area. Obtained with 2 attempts via saline-lock, tegaderm dressing applied to IV site., and tape applied to IV site. Entered: <KLW 7/25/2005 09:15>

07/25/05 09:12 MAR Given: Morphine 2-5 mg; Route: IV x1 PRN pain; Maximum dose =20 mg (3 times in MAR)
 Given , per IV Push 2 mg. IV site # 1 Entered: <KLW 7/25/2005 09:17>

07/25/05 09:14 MAR Given: Morphine 2-5 mg; Route: IV x1 PRN pain; Maximum dose =20 mg (3 times in MAR)
 Given , per IV Push 2 mg. IV site # 1 Entered: <KLW 7/25/2005 09:18>

07/25/05 09:15 MAR Given: Saline flush Normal Saline 0.9% 10 ml; Route: IV flush (3 times in MAR)
 Given , per IV Push 10 ml. IV site # 1 Entered: <KLW 7/25/2005 09:19>

07/25/05 09:15 Oral Contrast given Entered: <KLW 7/25/2005 09:21>

07/25/05 09:29 Oral Contrast Completed Entered: <KLW 7/25/2005 09:29>
Note:
 <KLW 07-25-2005 09:29>Pt. drank all of the contrast, CT notified.

07/25/05 09:30 MAR Response: Morphine 2-5 mg; Route: IV x1 PRN pain; Maximum dose =20 mg (3 times in MAR)
 Response unchanged. anxiety Entered: <KLW 7/25/2005 10:03>

07/25/05 09:31 MAR Given: Morphine 2-5 mg; Route: IV x1 PRN pain; Maximum dose =20 mg (3 times in MAR)
 Given , per IV Push 10 mg. IV site # 1 Entered: <KLW 7/25/2005 09:37>

07/25/05 09:35 MAR Given: Saline flush Normal Saline 0.9% 10 ml; Route: IV flush (3 times in MAR)
 Given , per IV Push 10 ml Entered: <KLW 7/25/2005 09:37>

07/25/05 10:00 MAR Response: Morphine 2-5 mg; Route: IV x1 PRN pain; Maximum dose =20 mg (3 times in MAR)
 Response Moderate pain relief 5/10 anxiety Entered: <KLW 7/25/2005 10:02>

07/25/05 10:01 MAR Given: Toradol 30 mg; Route: IV
 Given , per IV Push 30 mg. IV site # 1 Entered: <KLW 7/25/2005 10:03>

07/25/05 10:02 MAR Given: Saline flush Normal Saline 0.9% 10 ml; Route: IV flush (3 times in MAR)
 Given , per IV Push 10 ml. IV site # 1 Entered: <KLW 7/25/2005 10:03>

07/25/05 10:30 MAR Response: Toradol 30 mg; Route: IV
 Response unchanged. 6/10 Entered: <KLW 7/25/2005 11:16>

07/25/05 11:00 Urine obtained via clean catch UA. Sent to lab. Entered: <KLW 7/25/2005 11:17>

07/25/05 11:16 MAR Notes
 <KLW 07-25-2005 11:16>1104 - 6 mg Morphine given IV per site #1 followed by 10mg on Normal Saline IV site #1..

07/25/05 11:17	FlowSheet:	Input
	IV	
	Blood	
	PO	1000 ml

BryanLGH Medical Center-East - Lincoln , NE 68506-1299**Patient:** MCGINN, THOMAS P**DOB:** 12/25/1964**Age/Gender:** 40 M

7/25/2005 08:06 Groin pain

MR#: 000925810**Acct#:** 800475316**Private Phys:** Timothy H. Fischer MD**ED Phys:** Brent C. Bunz, MD**Total**

1000 ml

Entered: <KLW 7/25/2005 11:17>

07/25/05 11:43 Pain index - no goal
Words to describe:
Injury/position: right
Location: groin
Pain index: 6/10
Behaviors/Clinical signs: Resting quietly

Entered: <KLW 7/25/2005 11:43>

07/25/05 11:50 General Surgery Physician Carolyn S. Cody, MD notified by office. Time of call:

1150 Entered: <JLD 7/25/2005 11:50>

07/25/05 11:53 Carolyn S. Cody, MD General Surgery, returned call at 1151 Entered: <JLD 7/25/2005 11:53>

07/25/05 12:00 IV placement: IV site # 1 IV D/C'd IV Cath intact Dressing applied to site Entered: <KLW 7/25/2005 12:04>

07/25/05 12:04 Pain index (Adult)

Words to describe: burning**Aggravating factors:****Injury/position:** left**Alleviating factors:****Location:** groin**Goal for pain relief:****Pain index:** 6/10

Entered: <KLW 7/25/2005 12:05>

Behaviors/Clinical signs: moaning

07/25/05 12:04	Temp(F)	Rt.	Pulse	Resp	Syst	Diast	Pos.	O2 Sat	Rhythm	Amt O2
			87	16	124	73	S			

Entered: <KLW 7/25/2005 12:05>

DISPOSITION**NURSING**

Charge documentation only: XXX XXXXXXXXXXXX X X <KLW 07/25/05 12:08>

Nursing levels classification form <KLW 07/25/05 12:08>

No, this is not a trauma patient. <KLW 07/25/05 12:05>

The patient was discharged to home (AHR). Mode: ambulatory. Accompanied by: spouse/significant other. The patient's diagnosis, condition and treatment were explained to patient or parent/guardian. The patient/responsible party expressed understanding. A discharge plan has been developed. A case manager was not involved in the process. Aftercare instructions were given to the patient. <KLW 07/25/05 12:07>

Time discharged completed Monday, July 25, 2005 12:07 <KLW 07/25/05 12:07>

Final registration completed <TRB 07/25/05 09:25>

PHYSICIAN

I have reviewed nursing documentation for this patient's encounter. <BCB 07/25/05 08:59>

Medical decision making documented by dictation. <BCB 07/25/05 11:53>

Discharge from the ED. Discharge the patient to home (AHR). Patient's condition is improved. The patient is to follow-up with Carolyn S. Cody, 2222 S 16th #200, Lincoln (402) 475-9090, within 1-2 week(s). Purpose of referral: re-evaluation and further treatment <BCB 07/25/05 11:55>

Rx <BCB 07/25/05 11:55>

Work/School note <BCB 07/25/05 12:01>